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TRAUMA FOCUS GROUP THERAPY FOR VIETNAM VETERANS WITH PTSD

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Group therapy has been identified effective for the treatment of PTSD. The importance of creating a safe, supportive, and competent therapeutic arena is discussed. The assurance of physical and emotional safety, confidentiality, and "honesty" are identified as important factors in this process.

Post-Traumatic Stress Disorder (PTSD) is the new name for an old condition. It is a mental disorder which is a consequence of psychological and perhaps neuro-psychological responses to trauma which, while perhaps facilitating immediate survival, have gone on to generate long-term suffering. It appears that each generation has had to re-discover PTSD as if it had never been known before. This lapse in the continuity of memory attests to the power of the mind to insulate itself from awareness of psychic injury. The current generation discovered PTSD after the Vietnam War.

War is a prodigious source of the horrific events we associate with PTSD and military medical authorities have long appreciated the need to identify and respond to acute episodes of "shell shock" and "combat fatigue" (Jones & Hales, 1987). This appreciation reflects medical as well as military concern. However, medical concern for the long term health of the individual sometimes conflicts with military concern for maintaining the immediate fighting strength of the combat unit. Military psychiatry focuses on acute stress reactions because they impair the soldier's combat readiness. (Belenky, 1988) Military psychiatry focuses less on chronic stress reactions (such as PTSD) because they more often impair behavior in civilian life which is of less relevance to the armed forces.

The initial acceptance of PTSD as a diagnostic entity was slowed by debate between well-meaning advocates on the one hand and by those who chose to deny the authenticity of the disorder on the other. This debate is now largely at an end. PTSD has fully entered the mainstream of mental health theory and practice. In November of 1988, The Research Triangle Institute published the National Vietnam Veterans Readjustment Study, perhaps the best survey of Axis I mental disorders ever conducted. This study found the lifetime prevalence of post-Vietnam PTSD to be over thirty percent, or 960,000 cases. Of this group, nearly half still suffer today. PTSD is clearly a major, chronic health problem for Vietnam veterans.

Vietnam-related PTSD afflicts both men and women and is diagnosed by clinicians who take a thorough military history and then probe for trauma and post-trauma symptoms in all their patients over the age of 33. The criteria for diagnosing PTSD, in addition to the existence of a sufficient stressor, are repetitive "re-livings" of the trauma, psychic numbing, and persistent psychophysiological hyperarousal. Many PTSD patients resort to substance abuse to dampen symptoms of hyperarousal.

The authors' experience with PTSD was obtained during a decade of clinical work with combat veterans receiving inpatient treatment at the Specialized Treatment Center for PTSD. (Berman, Price & Gusman, 1982). The Center (now the

The work on which this paper is based was performed at Clinical Laboratory and Education Division, National Center PTSD, Fred D. Gusman, M.S.W., Director. This division the National Center for PTSD is located at the Palo Alto, ifornia, Department of Veterans Affairs Medical Center, nlo Park Division.

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Clinical Laboratory and Education Division of the National Center for PTSD) is located at the Department of Veterans Affairs Medical Center in Palo Alto, California.

Veterans treated at the Center are generally quite impaired. In 1983, Rozynko, Schutz and Gusman reviewed 151 sequential admissions and found that seventy percent were substance dependent and sixty-three percent were violence prone. Thirty-three percent admitted a history of suicide gestures. The Millon Clinical Multiaxial Inventory I showed the sample to be experiencing considerable subjective distress, significant mood disturbance, chronic alienation, impulsive anger, and generalized affective instability. These findings are congruent with similar studies reported by others. (Keane et al., 1988; Schauer et al., 1985; Silver & Iacono, 1984.) The Spiegel Hypnotic Induction Profile was also administered and demonstrated an unusually high trance capacity on the part of the veteran sample. (Spiegel, Hunt & Dondershine, 1988).

One of the essential elements in the Center's approach to trauma therapy is a therapeutic group called "Trauma Focus." This group's makeup is similar to groups described by Yalom (1983). Using Smith's (1985) categories, it is a level II, initial working rap group. The group ranged from 12 to 18 members (although 12 seemed to be the optimum size) and had a duration of 10–12 weeks. The purpose of the group is clearly stated to the members: to help them remember and examine their significant Vietnam experiences in order to integrate them with the rest of their lives.

Following several of Yalom's recommendations, the group is given a "high prestige" value, is led by senior staff, and is afforded precedence over competing activities. Trauma focus group, however, differs from Yaloms' groups in that the principle therapeutic work of the group is done in a regular and somewhat rigid fashion. Each participant is encouraged to tell about his or her high stress experiences in the war zone. A major therapeutic objective is to facilitate the retrieval of traumatic memories as clearly and as distortion-free as is possible, and to review the problematic, personal "conclusions and decisions" that emanated from them.

In addition to routine patient care activities typically assigned to mental health professionals at the Center, the authors also led the trauma focus therapy groups described above. They and others have emphasized this group format for treating combat-related PTSD for a variety of clinical reasons. These include: (a) the development of a sense of "belongingness" (Nardi, Wozner & Margolit, 1986); (b) the overcoming of isolation (Rosenheim & Elizur, 1977); (c) the restoration of a "broken" military group relationship by establishing warm relationships among therapy group members (Gorey, Triest & Margolit, 1986); and (d) the acceptance and control of patients' anger (Frick & Bogart, 1982). Such groups were also described at length by Lifton (1973), Walker and Nash (1981), Brende (1981), Smith (1985) and Scurfield (1986).

The authors further believe that the group process more readily protects patients from being overwhelmed by the power of therapy-released emotions and also provides a guilt-reducing, distortion-correcting, "fool proof" peer group. Smith (1985) made similar observations in his paper. In addition, Smith and others have stated that the group process fosters the kind of intra- and inter-personal integrative processes which are prerequisite to salutary and helpful changes in attitudes and values. We have also found that group therapy is less taxing for the trauma therapist and thus protects against the very real risk of "therapist burnout".

The purpose of this article is to describe the principles guiding the operation of these groups and to also review some procedural issues. It is written for therapists who are new to the field of trauma therapy. The authors wish to share their "hands on" experience. Their insights have evolved from their clinical experience and are largely known by other PTSD specialists. What this paper attempts to contribute is an outline of the steps one might take in the development of such a group and some specific procedures useful in treatment, particularly as regards problem situations that are likely to arise.

General Principles of Effective Treatment

Treating PTSD means treating combat-specific problems as well as one or more "companion" conditions such as Depression and Alcoholism. Methods for dealing with these latter conditions, however, are beyond the scope of this article. To treat veterans with combat-specific problems effectively, it is essential first to create an arena that is perceived by the patient to be safe, supportive, and competent. Only then is it possible to begin the essential therapeutic endeavor: the ideational and emotional processing of the traumatic

combat experience and the resolution of its residual traces in the patient's current life.

In establishing such an arena within a trauma focus therapy group, it is necessary to consider four factors: (1) physical safety; (2) emotional safety (including the confidentiality of communications); (3) honesty (including how to respond to suspected fabrications and distortions); and (4) control of distractions which can be used in the service of resistance. The group leader must clearly specify the limits of allowable behavior. Some pre-treatment training in the use of relaxation techniques and cognitive methods for emotional control is very helpful. (Hiley-Young, 1990)

Many PTSD patients overreact to perceived threat and are in tenuous control over their aggressive impulses. It must be made clear from the outset that neither violence nor the threat of violence is allowed. The group is an arena for exploring the past—not a stage on which to act it out. Similary, many Vietnam vets are highly judgmental. When this proclivity is acted out in group, one sees divisive peer ranking according to the amount or quality of combat experienced. If not opposed, this leads to "hardcores" expelling "wimps." Participants are told that mutual respect, compassion, and the notion that everyone "belongs" are the bulwark of therapy. It is also acknowledged that in war there are victims and there are perpetrators, that innocents are killed and moral limits sometimes crossed.

Treatment must be directed toward the trauma of Vietnam and not toward "trauma" which either didn't happen or which didn't traumatize. This leads to the basic rule that "war stories" are never allowed admittance to the group room. It is recognized, however, that the first "telling" of a traumatic event is never without distortion. Indeed, the event first revealed is often the least "energetic" of a series of events which need to be debriefed. Similarly, many patients choose to reveal their combat histories "starting at the end and working backwards to the beginning." It is very important for both group process and individual progress that the vets assist each other to uncover as much of the "truth" as possible. The line between this, however, and the destructive questioning of a peer's credibility or legitimacy should not be lightly crossed.

Therapeutic Goals & Objectives

Regardless of one's theoretical understanding with respect to trauma or its treatment, debriefing—the linguistic contextual analysis of the traumatic experience—is always central to therapy. The goal is to help the patient reconstruct his experience as completely and as accurately as possible. The therapist listens for inconsistencies and gaps and watches for micro-displays of discordant or dissociated affect. When any of these become apparent the patient is asked to fill in missing data or an attempt is made to probe for missing feelings. Strong emotions are vented, dissociated "truths" are reclaimed, and there is a final telling which may be sad but which no longer terrifies or overwhelms. The goal is reached when the story is emotionally and cognitively complete and congruent.

The emotions of trauma are powerful and, if released without proper patient preparation, may overwhelm and retraumatize. The patient may experience a flashback and act out his experience. This is never therapeutically useful and may be devastating to the patient's self-esteem. We do not mean to imply that strong emotions are to be avoided. Indeed, tolerating them is often the key to the recovery of the dissociated elements of a combat experience and to its ultimate resolution. Sometimes, therapy is conducted in a nether world of partial dissociation with the patient being here (the present) and there (in Vietnam) at the same time. The group leader must, however, maintain at all times his or her professional responsibilities as group leader.

In working with a particularly difficult patient, one of the authors allowed the veteran to become completely immersed in his combat reverie. As a result, the patient, dissociated into a "flashback" and began to act out the event. The patient had to be physically restrained to protect him and others from harm. Thereafter, the therapist was more alert to the need with this particular patient to interrupt his tendency to dissociate rather than to communicate in a more therapeutically useful fashion. The therapist found it useful initially to "guide" the veteran through his "telling" using a structured question and answer format. In addition, at intervals, the therapist would instruct the veteran to look right and left, to describe what was going on around him, to repeat what he had just said, and to take a "second look" at it from a different vantage point (from a helicopter high above the battle scene.) This process permitted the veteran to work through the combat event and eliminate its original power to control and overwhelm him whenever in the presence of precipitating stimuli.

Attributing acceptable meaning to events which have profoundly altered one's self-concept is necessary to the "new" self's continued journey through time. The "new" meaning must be compatible with living a normal life and must facilitate the restitution of shattered beliefs and expectations. Pre-treatment vets tend to view themselves as part-persons—without pasts and without futures. Post-treatment vets tend to view themselves as whole persons who have survived hellish events. They also see themselves as the product of a process of continuing change over time. They come to realize that they can continue this process of change in ways conducive to happiness. The integrating realization that Vietnam is as much a process as a place results in an increased quality of intra- and an inter-personal "connectedness." The self and others are re-valued in the light of more mature notions of what they were, who they are, and what they yet can be.

Clinical Management of the Trauma Focus Group

Experience suggests a therapy room of adequate size and sound proofing for a group of 8–12 vets and situated to minimize distractions and interruptions. Group membership should be limited to non-psychotic, "in-country" vets who have shown some measure of commitment to personal change. Adequate support systems should already be in place and prospective group members should have sufficient control over destructive impulses. Substance abuse must stop as a pre-condition to enrollment and the use of sedating doses of neuroleptics or benzodiazepines must be curtailed. The therapists's management of patient anxiety is the art as well as the substance of trauma therapy. It's control must not be left to the patient or his pills. We also strongly recommend that the primary therapist be assisted by a similarly experienced co-facilitator.

Group members are asked to introduce themselves and to state what they hope to get out of therapy. They are then asked to summarize their military histories. This introduction establishes the context of each person's participation. It also tells each vet that the Vietnam war was complex and that there is much for each of them to learn. For example, soliders assigned in the north often fought NVA regulars, "Mr. Charles," while soldiers assigned in the south more often fought Viet Cong, "Charlie." Some patients find it helpful to keep a private "trauma journal." This helps them begin to look at time-related and event-related personal changes. Finally, the group rules are presented and discussed. These rules include coming to sessions on time, not leaving sessions without permission, no smoking, and so on. Racist dogma, political rhetoric, and unfocused diatribes are prohibited as well.

In the majority of cases, veterans begin their combat "tellings" by reviewing events surrounding their arrival in Vietnam. Many contrast their expectations of Vietnam with how it really was. Feelings of disillusionment are inevitable. Some soldiers circled Vietnam before landing because their airport was under attack. Others landed amidst stacks of caskets waiting to be flown back to the "world." Many experienced the reality of war only later when they arrived at their units and met the wary attitudes of combat hardened soldiers towards the "cherries." They were FNG's ("fucking new guys") and jokes were made about how soon they might die. A first fire fight—with its chaotic roar of terror and violence—brought each new arrival the realization that he had very little control over whether he would live out that day or any of the more than 300 days yet to follow.

Group members begin to realize the processes through which they altered their pre-Vietnam attitudes and beliefs to conform with the new "realities" of war. For many, the desire to survive became the essential—if not the exclusive—motivator. They "learned" not to feel, to attach, or to care. They told themselves "It don't mean nothin'" when it did and they soon "forgot" this self-statement was only a slogan contrived to meet the exigencies of the moment. During the initial weeks of therapy, many combat "firsts" are explored. These initial tellings serve both to help patients "decompress" and to set the stage for a better understanding of the "adjustments" to combat which will be explored during later sessions.

After several weeks, the group's focus shifts to a review of each participant's day to day survival in the war zone and how each adapted to or defended against the circumstances which presented and the emotions evoked. Many times, a single episode would need more than one telling. Repeated tellings facilitate the recovery—often with cathartic force—of powerful but previously dissociated, repressed, or otherwise hidden fragments of trauma-related memory and emotion.

As the group begins to wind down, interests shift to final battles, leaving the war zone, and the "coming home" period. Actual combat events recede into painful memory—no longer overwhelming. For many soldiers, the events of the

"coming home" period were unexpectedly painful. Some were met by derision from protesters while others were feared as "baby killers and dope fiends." Finding a friend and a job were no easy tasks.

In the final series of group meetings, vets attempt to ferret out where "Vietnam" still operates in their current lives. Questions are asked and answers fashioned. "What rules of life did I bring home from the war? Do I still need them?" "What did I learn in Vietnam that I can use today?" At the end, loose ends are gathered up, fondnesses shared, and goodbyes said. A general admonition is given to keep open links to effective communication and continuous social contact and to seek help again if (when) problems recur.

Conclusions

PTSD is a chronic health problem affecting survivors of America's decade in Vietnam. Four essential components of therapy for this disorder are: (1) the analysis in context of combat with recovery of dissociated memories and affects; (2) the teaching of techniques which allow strong emotions to be tolerated without resort to neurotic escape; (3) the discovery of "acceptable" meanings for the combat experience; and (4) the realization that trauma is as much a process as a disorder and, as a process, it is comprehensible, manageable, and compatible with leading a relatively normal life.

Many combat veterans can be treated for PTSD using a specialized therapy group such as the one described above so long as the therapy group is accurately perceived as competent, compassionate, and safe. Trauma focus group therapy is also applicable to the treatment of victims of nonmilitary trauma such as violent crime, earthquake, hurricane, or other disaster contexts. However, we do not recommend the inclusion of victims of significantly different ages or of significantly disparate inciting events within a single therapy group. Trauma focus group therapy offers special advantages with respect to clinical and administrative efficacy and client-protection while minimizing the risk to the therapist of "burn out" and acting out.

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